

OVERVIEW

PALLIATIVE CARE IN HOSPITAL

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Tim Perawatan Paliatif
RSUP Dr. Kariadi – Semarang
2014

KEPUTUSAN MENTERI KESEHATAN REPUBLIK INDONESIA
NOMOR : 812/Menkes/SK/VII/2007
TENTANG
KEBIJAKAN PERAWATAN PALIATIF

LATAR BELAKANG:

Meningkatnya jumlah pasien dengan penyakit yang belum dapat disembuhkan baik pada dewasa dan anak seperti penyakit kanker, penyakit degeneratif, penyakit paru obstruktif kronis, cystic fibrosis, stroke, Parkinson, gagal jantung/heart failure, penyakit genetika dan penyakit infeksi seperti HIV/AIDS yang memerlukan perawatan paliatif, disamping kegiatan promotif, preventif, kuratif, dan rehabilitatif.

Incurable

Promotive

Curative

Palliative

Preventive

Rehabilitative



Masyarakat menganggap perawatan paliatif hanya untuk pasien dalam **kondisi terminal** yang akan segera meninggal.

Namun konsep baru perawatan paliatif menekankan pentingnya integrasi **perawatan paliatif lebih dini** agar masalah **fisik**, **psikososial** dan **spiritual** dapat diatasi dengan baik.



Rumah sakit yang **mampu** memberikan pelayanan perawatan paliatif di Indonesia masih terbatas di 5 (lima) ibu kota propinsi yaitu **Jakarta**, **Yogyakarta**, **Surabaya**, **Denpasar** dan **Makassar**.

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WHO Definition of Palliative Care

Palliative care is an approach that **improves** the quality of life of patients and their families facing the problem associated with **life-threatening illness**, through the **prevention and relief of suffering** by means of early identification and impeccable assessment and treatment of **pain and other problems, physical, psychosocial and spiritual.**

(WHO, 2010)

<http://www.who.int/cancer/palliative/definition/en/>

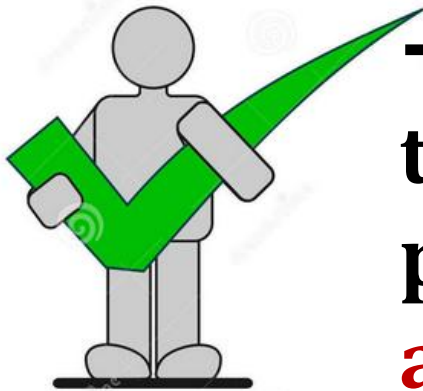
Palliative care:

- provides relief from **pain** and other **distressing symptoms**;
- affirms **life** and regards **dying** as a normal process;
- intends neither to hasten or postpone **death**;
- integrates the **psychological** and **spiritual** aspects of patient care;
- offers **a support system** to help patients live as **actively** as possible until death;
- offers a support system to help **the family cope** during the patients illness and in their own bereavement;
- uses **a team approach** to address the needs of patients and their families, including bereavement counseling, if indicated;
- will **enhance quality of life**, and may also positively influence the course of illness;

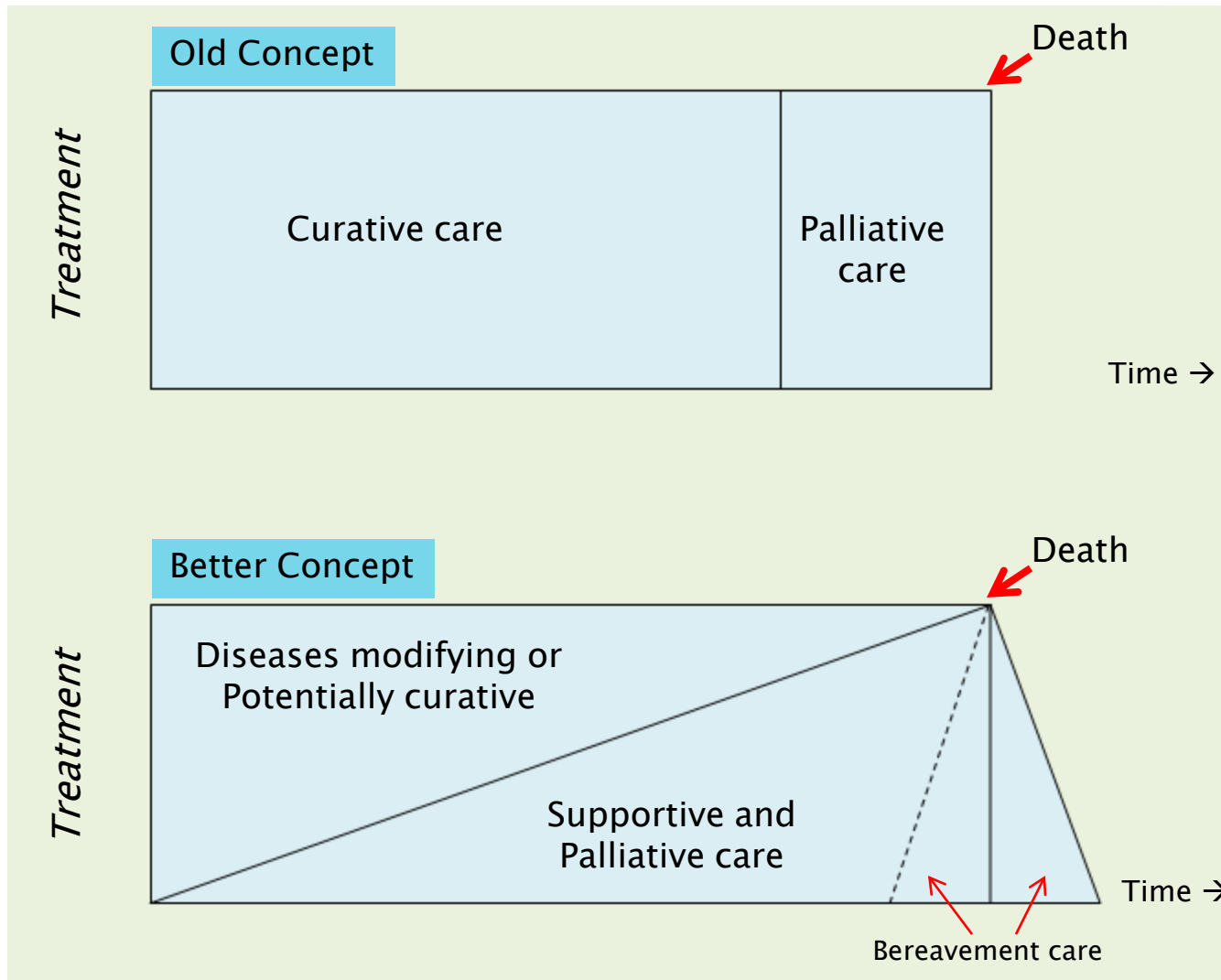
Palliative care should be initiated when the patient becomes symptomatic of their active, progressive, far-advanced disease and should **never be withheld until such time as all treatment alternatives for the underlying disease have been exhausted.**



Many health care workers believe that palliative care is the "soft option" adopted when "active" therapy stops!

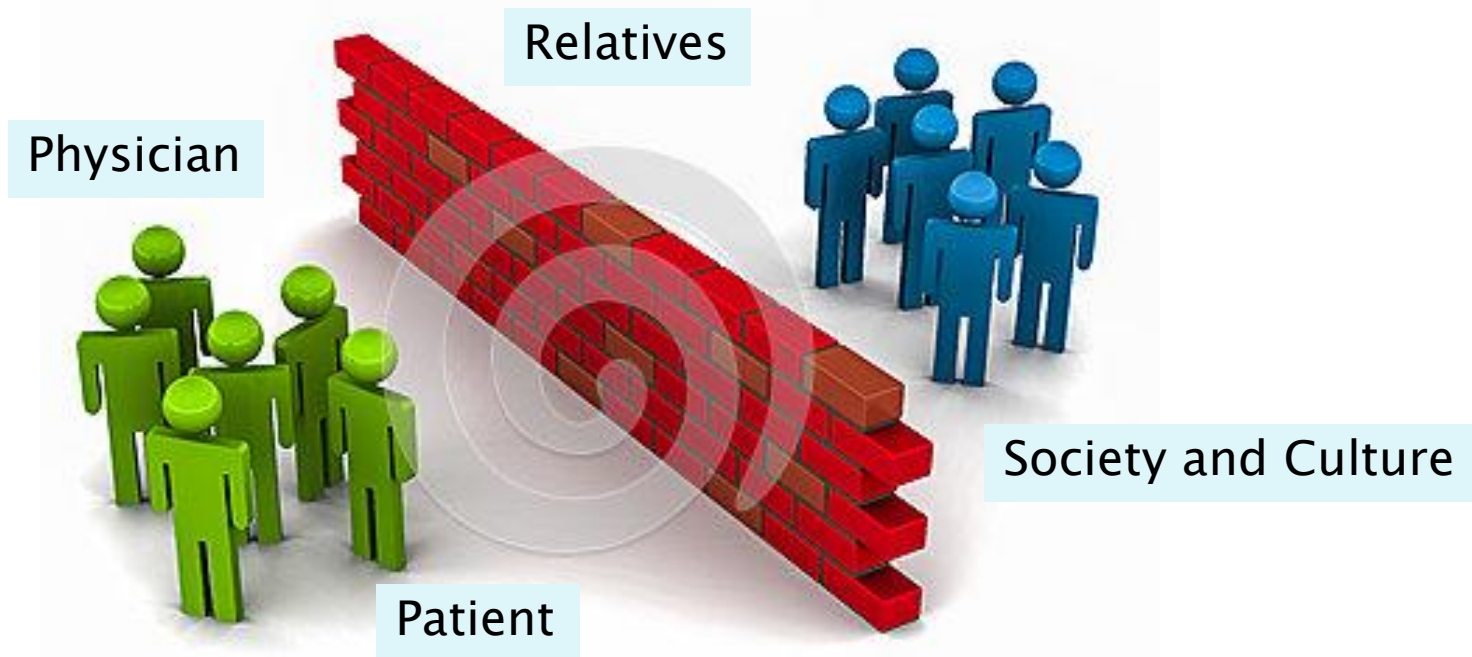


→ **Palliative care**, addressing all the patient's physical and psychosocial problems, is **active therapy**



Murray SA, Kendall M, Boyd K, Sheikh A.
 Illness trajectories and palliative care.
 BMJ. 2005; 330:1007-1011.

BARRIERS to PALLIATIVE CARE



dreamstime.com

Barriers related to the physician

- **poor prognostication**: does not recognise how advanced the patient's illness is
- may not recognise how much the patient is suffering
- lacks communication skills to address end-of-life issues
- believe they are already providing good palliative care and need no assistance
- **misunderstands** what a palliative care service does or has to offer
- does not want to hand over the patient's care: **loss of control, loss of income**
- opiophobia: worries the patient may become addicted to opioids or suffer severe side effects
- does not believe in palliative care
- **does not know of the palliative care service**



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Barriers related to the relatives

- they may **never have heard of palliative care** or a local service
- they may not know whom to ask about it
- they may **worry if they can afford it**
- they may fear what relatives and neighbours will say about home care
- they may not want many professionals visiting the home
- there may be patient-family **disagreement** about treatment options
- they may feel unskilled and unable to care for their loved one at home
- they may want the patient to stay at home or the hospital ward they are currently in
- they may fear unexpected emergencies at home and not know if the palliative care service can cope with them
- they may **fear** it may mean telling the patient they are **dying** (which may have been previously resisted)
- they may think it is **euthanasia by another name**



Barriers related to the patient

- they may have **unrealistic expectations** about their disease and prognosis
- there may have been no advance care planning/discussions
- they may not have heard of hospice or palliative care
- they may suspect that it is dismal, gloomy and frightening with people dying all around you and everyone talking about death
- they may suspect that people die as a result of euthanasia
- they may worry about opioid addiction
- they may not want to leave home or the unit they are currently in
- they may not want to have to develop relationships with new professionals



Barriers related to society and culture

- Ethnic minorities
- Language barriers
- **Poor or underprivileged**
- Rural communities
- Dying and death still remain, to a large extent, taboo subjects
- There is still a deeply held view that maintaining life—whatever its quality—is a prime responsibility of health care professionals and services.
- **Opiophobia**



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Breakthrough
and Jump
over the
barriers



Quality of Life

Well-being
Emotional
Social
Physical
Disease
Disability
Disorder

In general, **quality of life (QoL or QOL)** is the perceived quality of an individual's daily life, that is, an assessment of their well-being or lack thereof. This includes all **emotional**, **social**, and **physical** aspects of the individual's life.

In health care, **health-related quality of life (HRQoL)** is an assessment of how the individual's well-being may be affected over time by a **disease, disability, or disorder**.



(Wikipedia)

http://en.wikipedia.org/wiki/Quality_of_life_%28healthcare%29

Dimensi Kualitas Hidup yang diinginkan pasien paliatif :

1. Penanganan permasalahan fisik (luka, nyeri, mual, muntah, sesak nafas, dan lain-lain)
2. Kemampuan fungsional dalam beraktivitas
3. Kesejahteraan keluarga
4. Kesejahteraan emosional
5. Kemampuan melakukan aktifitas spiritual
6. Kemampuan melakukan fungsi sosial
7. Kepuasan pada layanan terapi
8. Orientasi masa depan (rencana dan harapan)
9. Kehidupan seksual, termasuk gambaran terhadap diri sendiri
10. Kemampuan / fungsi dalam bekerja

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Jennifer J. Clinch, Deborah Dudgeon dan Harvey Schipper (2000)



***Without research,
palliative care is an art,
not a science.***

<http://www.npcrc.org/>

ORIGINAL INVESTIGATION

Cost Savings Associated With US Hospital Palliative Care Consultation Programs

R. Sean Morrison, MD; Joan D. Penrod, PhD; J. Brian Cassel, PhD; Melissa Caust-Ellenbogen, MS; Ann Litke, MFA; Lynn Spragens, MBA; Diane E. Meier, MD; for the Palliative Care Leadership Centers' Outcomes Group

Results: Of the 2966 palliative care patients who were discharged alive, 2630 palliative care patients (89%) were matched to 18 427 usual care patients, and of the 2388 palliative care patients who died, 2278 (95%) were matched to 2124 usual care patients. The palliative care patients who were discharged alive had an adjusted net savings of \$1696 in direct costs per admission ($P = .004$) and \$279 in direct costs per day ($P < .001$) including sig-

Conclusion: Hospital palliative care consultation teams are associated with significant hospital cost savings.

Arch Intern Med. 2008;168(16):1783-1790



End of Life



Chrisye



Nira Stania



dr. Abdul Mun'im Idries, SpF

Dying is a 4D activity

Physical

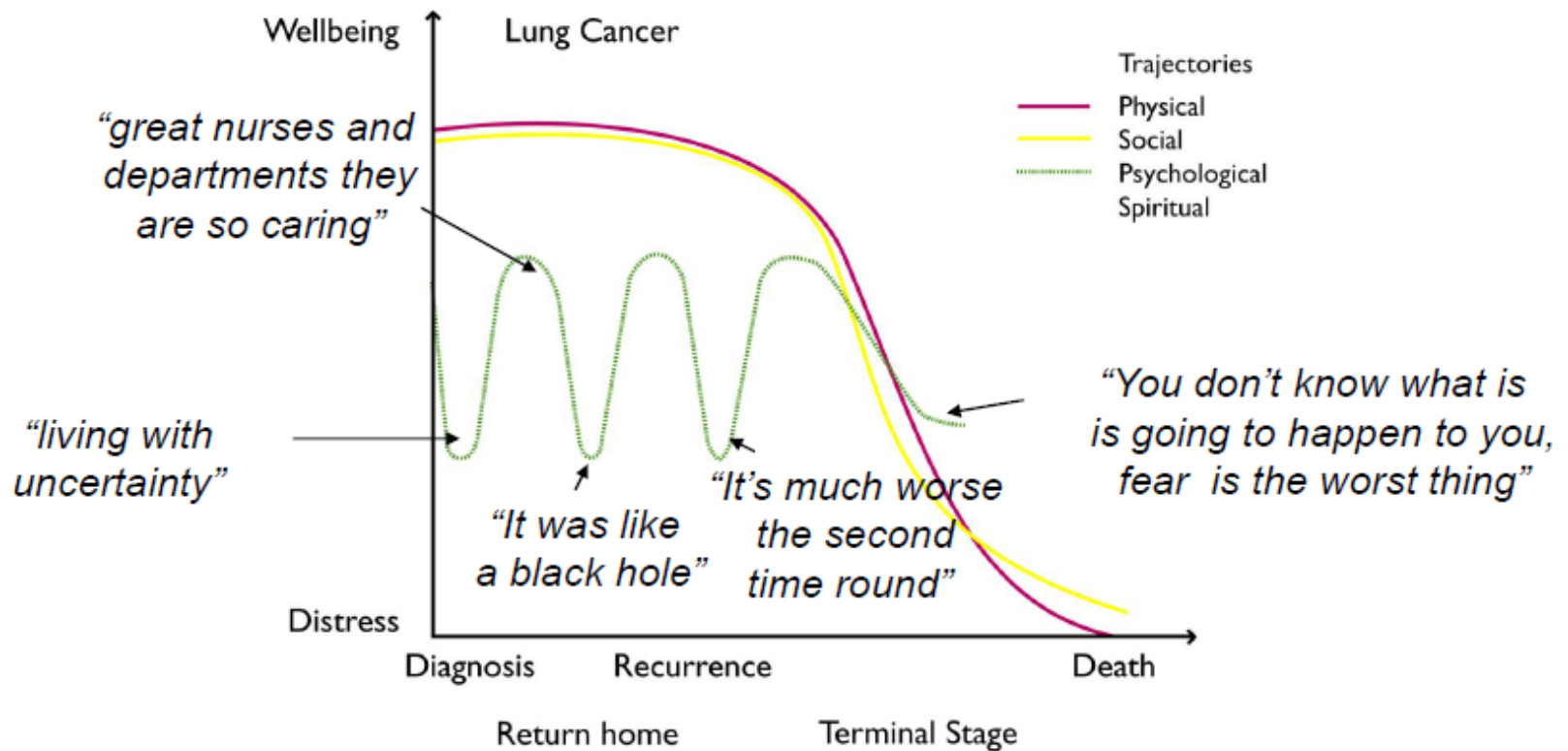
Psychological

Social

Spiritual

Scott A Murray (2010)
Concept of trajectories at the end of life: physical and other dimensions.

Murray SA, Kendall M, Grant E, Boyd K, Barclay S, Sheikh A.
 Patterns of social psychological and spiritual decline towards
 the end of life in lung cancer **J Pain Sympt Man** 2007; 34: 393-402



End of life

Percentage of U.S. adults who say there are circumstances where a patient should be allowed to die or medical staff should do everything possible to save the life of a patient in all circumstances.

- Sometimes allow the patient to die
- Always do everything possible to save the patient
- Don't know



SOURCE: Pew Research Center

DESERET NEWS GRAPHIC

“To cure sometimes, to relieve often, and to comfort always,”

Oxford Textbook of Palliative Medicine
Second Edition

Terima Kasih

